

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 135

CERTIFICATE OF DEATH

Dr. Lavinio

Reg. Dist. No. 290

1. PLACE OF DEATH County... <u>Talbot</u> City or town... <u>Easton</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 yrs.</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>Md.</u> County... <u>Talbot</u> City or town... <u>Easton</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Mary Armistead</u>				3. (b) Social Security Number <u>none</u>			
4. Sex <u>Female</u> 5. Color or race <u>Colored</u> 6. (a) Single, married, widowed, or divorced <u>Married</u> 6. (b) Name of husband or wife <u>James Armistead</u> 7. Birth date of deceased (mo., day, yr.) <u>Jan-10-1880</u> 6. (c) If alive, give age <u>77</u> years				MEDICAL CERTIFICATION 20. DATE OF DEATH <u>Jan 23rd 1946</u> at <u>9:45 A.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Dec 9th 1945</u> to <u>Jan 23rd 1946</u> and that I last saw him alive on <u>Jan 20th 1946</u> Immediate cause of death <u>Acute Bright's Disease</u> Due to <u>Emphysema</u> Due to <u>Emphysema</u> Other conditions <u>Autothemia</u> <u>Suppuration</u> (Include pregnancy within 3 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
8. AGE: Years <u>66</u> Months <u>-</u> Days <u>13</u> If less than one day <u>hrs.</u> <u>-</u> <u>min.</u> 9. Birthplace <u>Williamsburg, Va.</u> (Town, county, and state) 10. Usual occupation <u>Housewife</u> 11. Industry or business				DURATION <u>1 mo</u> <u>1 wk</u>			
12. Name <u>James Jones</u> 13. Birthplace <u>Williamsburg, Va.</u> 14. Maiden name <u>unknown</u> 15. Birthplace				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide... <u>✓</u> Date of... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?			
16. Informant <u>Gertrude Smith</u> Address <u>326 Talbot St. Easton Md.</u> 17. Burial <u>Colored Audubon Trappe</u> (Burial, cremation, or removal. Which?) Date thereof <u>Jan 26-46</u> Cemetery or crematory <u>Trappe, Md.</u> Location <u>Robert D. Williams</u> 18. Funeral director <u>Easton, Md.</u> Address				23. SIGNATURE <u>Sherris</u> <u>St. Michaels</u> M. D. or other Date signed <u>1-25-46</u>			
19. (Date rec'd by registrar) <u>1/24 1946</u> Registrar <u>N. H. Neer</u>							

RECEIVED

JAN 29 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-8

CERTIFICATE OF DEATH

00905

Reg. Diat. No. 294

1. PLACE OF DEATH: County..... <i>Calvert</i> City or town..... <i>Wittman</i> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <i>37 years</i> Hospital, institution, or street address where death occurred: How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <i>Maryland</i> County..... <i>Calvert</i> City or town..... <i>Wittman</i> (If outside city or town limits, write RURAL and give nearest town) Street No..... <i>Rural</i> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <i>Allen Walker Beachley</i>				3. (b) Social Security Number ✓			
4. Sex <i>Male</i>		5. Color or race <i>White</i>		6. (a) Single, married, widowed, or divorced <i>Single</i>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife ✓				20. DATE OF DEATH <i>Jan. 31</i> 19. <i>46</i> at <i>1 A.</i> M			
7. Birth date of deceased (mo., day, yr.) <i>April 5, 1875</i>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19....., to..... 19..... and that I last saw him..... alive on..... 19..... Immediate cause of death..... <i>Lymphosarcoma</i>			
8. AGE: Years <i>70</i> Months <i>9</i> Days <i>26</i> If less than one day..... hrs. min.		6. (c) If alive, give age years		DURATION <i>Years</i>		Due to <i>Primary in mediastinal lymph node. Duration several years.</i>	
9. Birthplace <i>Penn. Co. Pa.</i> (City, county, and state)				Due to <i>Sw. P.</i>			
10. Usual occupation <i>Farmer</i>				Other conditions			
11. Industry or business <i>Farming</i>				(Include pregnancy within 8 months of death)			
FATHER		12. Name <i>John C. Beachley</i>		Major findings of operations			
13. Birthplace <i>Mary Co. Md.</i>		14. Maiden name <i>Mary C. Walker</i>		Date of op.....			
MOTHER		15. Birthplace <i>Pa.</i>		Autopsy results			
16. Informant <i>Alfred David M. Cohen</i>		Address <i>Wittman Md.</i>		PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. (Burial, cremation, or removal. Which?) <i>Burial</i>		Date thereof <i>Feb. 3, 1946</i> (month) (day) (year)		22. VIOLENCE: If death was due to external cause, fill in the following;			
Cemetery or crematory <i>Beachdale Cemetery</i>		Location <i>Sw. P. Pa.</i>		Accident, suicide, or homicide..... Date of.....			
18. Funeral director <i>J. Ellis Clark</i>		Address <i>Easton Md.</i>		Where did injury occur?..... (City or town) (County) (State)			
19. 2/1		19. 46		Injured at home, farm, industry, public place (where?).....			
(Date rec'd by registrar)		Registrar <i>N. D. Neerius</i>		Means of injury..... Injured at work?.....			
23. SIGNATURE <i>Louis P. Mott M.</i>		Address <i>Easton Md.</i>		Date signed <i>2-1-46</i>			

RECEIVED
MAR 4 1946
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 780

00906

CERTIFICATE OF DEATH

Reg. Dist. No. 292

1. PLACE OF DEATH: Talbot Co Md
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Mary E. Camber

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

Female Colored Married6. (b) Name of husband or wife..... Killian T. CamberB. (c) If alive, give age..... 84 years7. Birth date of deceased (mo., day, yr.)..... 29 April 1864

8. AGE: Years..... 81 Months..... 9 Days..... - If less than one day..... hrs..... min.....

9. Birthplace..... Talbot Co Md

(Town, county, and state)

10. Usual occupation..... Laboer

11. Industry or business.....

12. Name..... Henry G. Larnot13. Birthplace..... Talbot Co Md14. Maiden name..... Ann B. Bailey15. Birthplace..... Talbot Co Md16. Informant..... Killian T. CamberAddress..... Talbot Co Md17. (Burial, cremation, or removal. Which?)..... Burial Date thereof..... Feb 2/46

(month) (day) (year)

Cemetery or crematory..... Talbot CemeteryLocation..... Legion H. Buzman18. Funeral director..... CamberidgeAddress..... Talbot Co Md19. Jan 31st 1946 Date rec'd by registrar..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 30 1946 at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 4 1946 to Jan 30 1946and that I last saw him alive on Jan. 30 1946Immediate cause of death..... Cerebral Hemorrhage DURATION..... 26 daysDue to..... Hypertension 3 years

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Hayward T. Webb M.D.Address..... Easton, Md. Date signed..... 1/30/46

MARGIN RESERVED FOR BINDING

VS A15

9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 3 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

FILM No. 100 JAN 21 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital, Easton, Md.

How long in hospital or institution?

8 hr. 10 min.

3. (a) FULL NAME

John Phillip Cohee

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 7 1922

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

23

22

✓

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Soldier U.S. Army

11. Industry or business

FATHER

12. Name

John P. Cohee

13. Birthplace

Md.

MOTHER

14. Maiden name

Mildred Collison

15. Birthplace

Md.

16. Informant

John P. Cohee

Address

Rhodesdale

17.

(Burial, cremation, or removal. Which?)

Date thereof Jan 12 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

1/11

1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County Dorchester

City or town Rhodesdale
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1946 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 9 1946 to January 9 1946

and that I last saw him alive on January 9 1946

Immediate cause of death

Fractured skull

Due to

Auto accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1-8-46

Where did injury occur? in front Carline 2nd
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) public highway

Means of injury auto accident Injured at work? no

23. SIGNATURE

Lawson George Corns M. D. or other

Address Dorchester Md Date signed 1/10/46

96412 W M
R12 111
JAN 17 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

00908

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot County
 City or town Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour 37 min.Hospital, institution, or street address where death occurred:
Memorial Hospital, Easton, Md.How long in hospital or institution? 1 hour 37 min.

3. (a) FULL NAME

Baby Boy Coleman #1

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

B. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

1-2-46

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1 hrs. 37 min.

9. Birthplace

Easton, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

Howard Coleman

13. Birthplace

Preston Md.

14. Maiden name

Sarah E. Koehler

15. Birthplace

Tremont Pa.

16. Informant

Address

Mrs. Howard Coleman
Easton Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

1/3/46
(month) (day) (year)

Cemetery or crematory

Memorial Hospital

Location

Easton Md.

18. Funeral director

Address

Memorial Hospital
Easton Md.

19.

(Date rec'd by registrar)

19 46M. H. Morris

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 1-2- 19 46 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 2 19 46 to Jan. 2 19 46and that I last saw him alive on Jan. 2 19 46

Immediate cause of death

Prematurity

DURATION

5 1/2 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Tyler Baker M.D.

M. D. or other

Address Easton Md. Date signed 1/3/46

RECEIVED

JAN 14 1946

RUPE 4 0 7 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot CountyCity or town Easton Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 minHospital, institution, or street address where death occurred:
Memorial Hospital, Easton, Md.How long in hospital or institution? 45 min

3. (a) FULL NAME

Baby Boy Coleman #2

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

1-2-46

6. (c) If alive, give age.....years

8. AGE:

Years

Months

Days

If less than one day

hrs.

45 min.

9. Birthplace

Easton Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

Howard Coleman

13. Birthplace

Preston Md

14. Maiden name

Lulah E. Koehler

15. Birthplace

Tremont Pa

16. Informant

Mrs Howard Coleman

Address

Easton Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

1/3/46
(month) (day) (year)

Cemetery or crematory

Memorial Hospital

Location

Easton Md

18. Funeral director

Memorial Hospital

Address

Easton Md

19.

(Date rec'd by registrar)

1/319 46N.H. Neuner

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Talbot

City or town

Easton
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

1-2

19

46 at 10 P 15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 2

19

46

to

Jan. 2

19

46

and that I last saw him alive on

Jan. 2

19

46

Immediate cause of death

prematurity

DURATION

5 1/4 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Baker M.D.
Easton, Md.

M. D. or other

Address

Date signed

1/3/46

RECEIVED
JAN 14 1946
BUREAU V.E.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01086 290

1. PLACE OF DEATH:

County Talbot
 City or town Williamsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 days
 Hospital, institution, or street address where death occurred:
Easton Rd
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Williamsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Outside
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary M Cooper

3. (b) Social Security Number

4. Sex female 5. Color or race Colored 6.(a) Single, married, widowed, divorced Married
 6.(b) Name of husband or wife Elephanter Cooper
 7. Birth date of deceased (mo., day, yr.) Jan. 30, 1882 8.(c) If alive, give age 170 years
 8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Talbot Co Md
 (Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name Joseph Mc Daniel

13. Birthplace Talbot Co, Md

MOTHER 14. Maiden name Mc Daniel

15. Birthplace Talbot Co, Md

16. Informant Elephanter Cooper

Address Williamsburg Talbot Co

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Jan 14/46
 (month) (day) (year)

Cemetery or crematory Cemetery

Location Talbot Co, Md

18. Funeral director South W. Bayneum

Address Cambridge Rd

19. Jan 23 19 46 M. H. Neuse
 (Entered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 19 46, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 19 46, to Jan 22 19 46

and that I last saw him alive on Jan. 22 19 46

Immediate cause of death Intussusception DURATION 7 days

Due to Chronic Constipation

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work?

23. SIGNATURE Hayward T. Webb, M.D. M. D. or other

Address Easton, Md Date signed 1/22/46

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MAY 1 1946
BUREAU V. A.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

00910

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)

Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

John Winfred Covington

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 4, 1946 19... at 6:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on Jan. 3, 1946 19...

Immediate cause of death

Acute coronary disease

DURATION

1 hr

Due to Embollic or Thrombotic in
etiology ?

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. B. Shewell

M. D. or other

Address St. Michaels, Md Date signed 1.7.46

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof 1 7 46
(month) (day) (year)Cemetery or crematory CemeteryLocation St. Michaels18. Funeral director J. Norman MarshallAddress St. Michaels, Md.

19.

Jan 7
(Date rec'd by registrar)

19.

46 John H. Hucobles
Local Registrar

RECEIVED

FEB 5 1946

BUREAU V.S.

VS A15

1. PLACE OF DEATH:
County Eastern
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For non-veterans give residence of mother)
State Ma. County Talbot.
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME Alma Belle Davidson
3. (b) Social Security Number 215-16-8654

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) April 21-1921 6. (c) If alive, give age _____ years
8. AGE: Years 24 Months 8 Days 20 If less than one day _____ hrs. _____ min.
8. Birthplace Chick, Pa.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. Name Alex Davidson
13. Birthplace Easton, Md.
14. Maiden name Ella Henry
15. Birthplace Easton, Md.
16. Informant Alex Davidson
Address Easton, Md.
17. Burial Frederick Cemetery
(Burial, cremation, or removal, Which?) Date thereof Jan 14-46
(month) (day) (year)
Cemetery or crematory Frederick Cemetery
Location Easton, Md.
18. Funeral director John D. Williams
Address Easton, Md.
19. 1/11 19 46 N. H. Neer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Jan 10th 1946 at 11:45 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Jan 10 1946
and that I last saw u alive on Dec 15, 1945
Immediate cause of death Pulmonary Tubercu
losis
DURATION 2 yrs
Due to
Due to
Other conditions Tatto Disease
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. ✓
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of ✓
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?
23. SIGNATURE J. Henry M. D. or other
A. Michael Date signed 1.12.46

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED

JAN 17 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

CERTIFICATE OF DEATH

00912

Reg. Dist. No. *290*

1. PLACE OF DEATH:

County... *Talbot*
 City or town... *Federalburg Eastern*
 (if outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *10 days*
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? *10 days*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... *Maryland* County... *Caroline*
 City or town... *Federalburg*
 (if outside city or town limits, write RURAL and give nearest town)
 Street No.
 (if rural, give LOCATION) ☒
 2. (a) If veteran, name War.

3. (a) FULL NAME

Henry Dickerson

3. (b) Social Security Number

4. Sex

MA

S. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

*Oct.**1872*

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

74

..... hrs. min.

9. Birthplace

Delaware
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Joseph Dickerson

13. Birthplace

Delaware

14. Maiden name

Mary

15. Birthplace

Laurel Del.

16. Informant

Riggin & Cooper

Address

Laurel Del.

17.

(Burial, cremation, or removal, which?)

Date thereof

1/8/46
(month) (day) (year)

Cemetery or crematory

Laurel Del.

Location

Laurel Del.

18. Funeral director

Riggin & Cooper

Address

Laurel Delaware

19.

(Date rec'd by registrar)

19

*46**N.H. Neir*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... *January 5* 18... *46* at *11 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Dec 26**19**45*to *Jan 5* 19... *46*

and that I last saw him alive on

*Jan 5*19... *46*

Immediate cause of death

Myocardial Failure

DURATION

*2 da.*Due to... *Chronic Myocarditis**See med.*

Due to

Other conditions

*Bronchitis pneumonia**1 wk.*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. Tyler Baker

M. D. or other

Address

Laurel

Date signed

1/11/46

RECEIVED

JAN 17 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 153

CERTIFICATE OF DEATH

Reg. Dist. No. 00913 290

1. PLACE OF DEATH:

County TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town St. Michaels

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Bertha Fairbanks

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced MarriedB. (b) Name of husband or wife Mr. Alfred Fairbanks7. Birth date of deceased (mo., day, yr.) Dec. 12, 1909B. (c) If alive, give age 36 years8. AGE: Years 36 Months 1 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Oxford Md.

(town, county, and state)

10. Usual occupation H. W.

11. Industry or business

12. Name Mr. Clarence Alkason13. Birthplace Easton, Md.14. Maiden name Katie Baynard15. Birthplace Oxford Md.16. Informant Mr. Alfred FairbanksAddress St. Michaels, Md.17. (Burial, cremation, or removal, Which?) Burial Date thereof Jan. 24, 1946

(month) (day) (year)

Cemetery or crematory St. MichaelsLocation St. Michaels, Md.18. Funeral director J. H. MarshallAddress St. Michaels, Md.19. 1/22 19 46 N. H. Neirnes

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 19 46 at 3:10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 45 to January 21 19 46 and that I last saw him alive on January 21 19 46Immediate cause of death Uremia

DURATION

7 daysDue to HypertensionDue to Long standing chronic Disarrangement 3 years

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Positive. Hypertension, atherosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE N. H. Palmer M. D.

M. D. or other

Address Easton, Maryland Date signed Jan. 24/46

RECEIVED
FEB 3 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 294

1. PLACE OF DEATH:

County TalbotCity or town Wittman
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs 4 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County TalbotCity or town Wittman, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Linda Mae Louise Fairbank

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced Child

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug 25-19438. AGE: Years 2 Months 4 Days 1 If less than one day _____ hrs. _____ min.9. Birthplace Wittman, Talbot Co Md
(Town, county, and state)10. Usual occupation Child

11. Industry or business _____

12. Name Millard Fairbank13. Birthplace Wittman Talbot Co. Md14. Maiden name Mary Marshall15. Birthplace Wittman, Talbot Co. Md.16. Informant Millard FairbankAddress Wittman Md17. Burial Date thereof Jan 19 1946
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Christ CemeteryLocation St Michaels Md18. Funeral director Newnam & HarrisonAddress St Michaels Md.19. Jan 25th 19 46 Anne C. Thomas
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 19 46 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 19 46 to Jan 26 19 46
and that I last saw her alive on Jan 26 19 46Immediate cause of death acute Relapsing Fever DURATION 2 wksDue to Influenza Pneumonia

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE Eugene P. Kelly MD M. D. or other _____

Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 5 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 71

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:
County Talbot
City or town Easton Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 da.
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 7

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Easton Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME
Charles E. Hampton

3. (b) Social Security Number

4. Sex M 5. Color or race W. 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary E. Hampton
6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 14, 1875

8. AGE: Years 70 Months 8 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Easton Md.
(Town, county, and state)

10. Usual occupation Farmer (retired)

11. Industry or business _____

12. Name James E. Hampton

13. Birthplace Trappe Md.

14. Maiden name Mary Harrison

15. Birthplace Trappe Md. (P)

16. Informant James E. Hampton

Address Easton Md.

17. Burial Date thereof 2/2/46
(Burial, cremation, or removal, Waiver) (month) (day) (year)

Cemetery or crematory Spring Hill

Location Easton Md.

18. Funeral director Mauda E. Mowbray

Address Easton Md.

19. 2/1 19 46 N.H. Newsum
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-31 19 46 at 3:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-26 46 to 1-30 46
and that I last saw him alive on 1-30 46

Immediate cause of death Insanition

Due to Acetaminophen

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter F. Buell Med.
M. D. or other _____

Address Easton Md. Date signed 1-31-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 8 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 294

00916

1. PLACE OF DEATH:

County... *Talbot*
 City or town... *Highman*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... *Life*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... *Maryland* County... *Talbot*
 City or town... *Highman*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Russell W. Harrison

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male white married

6.(b) Name of husband or wife

Margaretta

7. Birth date of deceased (mo., day, yr.) 11. 25-1899

8. AGE: 46 Years 20 Months 20 Days If less than one day

9. Birthplace Talbot Co. Md.

10. Usual occupation Ice & oil dealer

11. Industry or business own business

12. Name R. Taylor Harrison

13. Birthplace Highman Md.

14. Maiden name Clara Stewart

15. Birthplace Poplar Island Md.

16. Informant Geo. T. Harrison

Address Highman Md.

17. Burial Date thereof 1-13-46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Highman Methodist

Location Highman Md.

18. Funeral director Norman Marshall

Address Michaels

19. 1/13/46 19 2 Harrison Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 11 1946 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11 1946 to Jan 12 1946

and that I last saw him alive on Jan 11 1946

Immediate cause of death cerebral hemorrhage 2 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Guy W. Ricks

Address Highman Md. Date signed Jan 12/1946

RECEIVED
JAN 18 1946
BUREAU V.S.

RECEIVED
JAN 18 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 294

1. PLACE OF DEATH:

County Talbot

City or town Fairbank
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Talbot

City or town Fairbank
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Laura Jeanette Howeth

3. (b) Social Security Number

none

4. Sex female

5. Color or race white

6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife J. Frank Howeth

7. Birth date of deceased (mo., day, yr.) Dec. 23 - 1886

6. (c) If alive, give age 65 years

8. AGE: Years 59 Months 0 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Fairbank Talbot Co. md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James H. Callis

13. Birthplace Virginia

14. Maiden name Elizabeth Duncan

15. Birthplace Tilghman, md

16. Informant J. Frank Howeth

Address Fairbank, md

17. Burial Date thereof Jan 16 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Fairbank, md.

18. Funeral director Newnam & Harrison

Address St. Michaels md.

19. 1/6 19 46 G. F. Jackson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 19 46 at 8:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 19 46 to Jan 13 19 46 and that I last saw him alive on Jan 13 19 46

Immediate cause of death Coronary occlusion

DURATION

5 min.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE G. F. Jackson M. D. or other

Address Tilghman, md Date signed Jan 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 18 1946

BUREAU U S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-2

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:
 County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother) Talbot
 State Maryland County
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary F. Hunt

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Joseph B. Hunt
 7. Birth date of deceased (mo., day, yr.) December 3, 1867 B.(c) If alive, give age 79 years
 8. AGE: Years 78 Months 1 Days 8 If less than one day
 .hrs. min.

9. Birthplace Talbot, St. Michaels, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John H. Burns
 13. Birthplace St. Michaels, Maryland

14. Maiden name Louise Echardt
 15. Birthplace Virginia

16. Informant Mrs. Mildred Mansfield
 Address St. Michaels, Maryland

17. Burial January 13, 46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Cemetery
 Location St. Michaels, Maryland

18. Funeral director J. Norman Marshall
 Address St. Michaels, Maryland

19. Jan 14 1946 John H. Burns
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11 1946 800 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 and that I last saw him alive on 19
 Immediate cause of death

Chronic myocarditis

DURATION

years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis H. Burns
 M. D. or other
 Address St. Michaels Date signed 1-12-46

RECEIVED

FEB 5 1946

BUREAU V.8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... Eastern Talbot
City or town... 17 hrs.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution?
17 hrs.

3. (a) FULL NAME

Baby William Franklin Hurreth

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Talbot
City or town... Ybttman
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 11 - 1946 6. (c) If alive, give age... years

8. AGE: Years Months Days If less than one day
0 yrs. 17 hrs. 0 min.

9. Birthplace... Eastern Talbot Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name William Hurreth, Jr.
13. Birthplace Md.

14. Maiden name Mary L. Hellemann
15. Birthplace Md.

16. Informant Memorial Hospital
Address Eastern Md.

17. Cremation Date thereof Jan. 11 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Memorial Hospital
Location Eastern Md.

16. Funeral director Memorial Hospital
Address Eastern Md.

19. 1/11 19 46 N.H. Neiers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11 19 46 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 11 to Jan. 11 19 46
and that I last saw him alive on Jan. 11 19 46

Immediate cause of death Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Tyler Baker M. D. or other

Address Eastern Md. Date signed 1/11/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 3 1946

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00920

Reg. Dist. No. 291

1. PLACE OF DEATH:

County TalbotCity or town Royal Oak
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Perry Jenkins

4. Sex

Male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

widower6. (b) Name of husband or wife Georgia Jenkins

7. Birth date of

deceased (mo., day, yr.)

December 25 1853

6. (c) If alive, give age ----- years

8. AGE:

Years

Months

Days

If less than one day

927

hrs.

min.

9. Birthplace Royal Oak, Talbot, Maryland
(Town, county, and state)10. Usual occupation laborer

11. Industry or business

FATHER

12. Name George Jenkins13. Birthplace Royal Oak, Md.

MOTHER

14. Maiden name Liza Harris15. Birthplace Royal Oak, Md.16. Informant Georgia JenkinsAddress Royal Oak, Md.17. burial Date thereof 1 4 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory cemeteryLocation Royal Oak, Md.18. Funeral director J. Norman MarshallAddress St. Michaels, Md.19. Jan 2 19 46
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Royal Oak
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 January 19 46, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

25 December 19 44, to 1 Jan 19 46and that I last saw him alive on 1 December 19 45

Immediate cause of death

nephritis chronic
interstitial

DURATION

1 yr 6 mo

Due to _____

Due to _____

Other conditions

infirmities of
age
(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

P. L. Jenkins, M.D.
Address Royal Oak, Md. Date signed 1/2

M. D. or other

RECEIVED

FEB 5 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92P)

CERTIFICATE OF DEATH

00921

Reg. Dist. No. 491

1. PLACE OF DEATH:

County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

F. M. Chatham Jones

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Rowena Jones6.(c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) October 12, 18698. AGE: Years 76 Months 4 Days 6 If less than one day
.....hrs.min.9. Birthplace St. Michaels
(Town, county, and state)10. Usual occupation Boat Builder

11. Industry or business

12. Name Edward Jones13. Birthplace St. Michaels14. Maiden name Elizabeth Marshall15. Birthplace St. Michaels16. Informant Rowena JonesAddress St. Michaels17. Burial Date thereof Jan. 9, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation St. Michaels18. Funeral director J. Norman MarshallAddress St. Michaels19. Jan 9 1946 John H. Marshall
(Date rec'd by registrar) (19) 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 7, 1946 19..... at 5:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19, 1945 to Jan. 7, 1946 19.....
and that I last saw him alive on Jan. 6, 1946 19.....Immediate cause of death Coronary thromboses

DURATION

Due to arterio-sclerosis with chronic mitral insufficiency
Due to insufficiency with edema of legs
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Henry Willson, M.D. M. D. or otherAddress St. Michaels, Md. Date signed Jan. 8 '46

RECEIVED
FEB 5 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County.....Talbot
 City or town.....Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....21 da.
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution?.....21 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Maryland County.....Talbot
 City or town.....Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Edward Kirby

3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Widowed
 6.(b) Name of husband or wife.....Sallie Sanders Kirby
 7. Birth date of deceased (mo., day, yr.).....Feb. 17, 1864
 8. AGE: Years.....81 Months.....11 Days.....13 If less than one day.....hrs.min.

9. Birthplace.....Talbot Co. Md.
 (Town, county, and state)

10. Usual occupation.....Seafarer

11. Industry or business.....Easton, Md.

12. Name.....John Kirby

13. Birthplace.....Md.

14. Maiden name.....Mrs. Kirby

15. Birthplace.....

16. Informant.....Mrs. Lucie Seaman

Address.....Baltimore Md.

17. Burial Date thereof.....2/2/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Spring Hill

Location.....Easton, Md.

18. Funeral director.....Edwin Park

Address.....Easton, Md.

19. 2/1 19 46 H. H. Neeser
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....January 30 19 46 at 9:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 46 to Jan 30 19 46

and that I last saw him alive on 1-31 19 46

Immediate cause of death.....Acute myocardial infarction

Due to.....Intermittent heart block

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

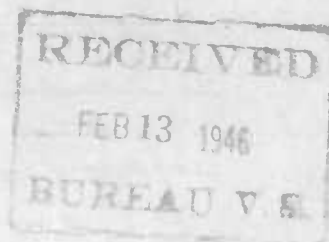
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....J. Tyler Baker M.D.

Address.....Easton, Md. Date signed.....2/2



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry Morris Marshall

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Agnes Rice Townsend7. Birth date of deceased (mo., day, yr.) Dec. 25, 18706. (c) If alive, give age 73 years

8. AGE:

Years 75 Months 1 Days 3 It less than one day _____ hrs. _____ min.9. Birthplace Markham, Fauquier, Virginia
(Town, county and state)10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Thomas Marshall13. Birthplace Va.MOTHER 14. Maiden name Courtney H. Marshall15. Birthplace Va.16. Informant Mr. D. D. DattelleAddress Easton, Md.17. Burial Date thereof 1/30/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Trinity ChurchyardLocation Markham Va.18. Funeral director W. B. ClarkAddress Easton, Md.19. 1/28 19 46 N. H. Neeris
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County FauquierCity or town Markham
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 19 46 at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 46 to _____ 19 46and that I last saw him alive on Jan 15 19 46Immediate cause of death Coronary ThrombosisDue to Angina Pectoris

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

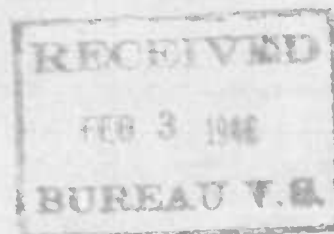
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Lynn Balm M.D.
M. D. or other _____Address Easton Date signed 1/29/46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 943

CERTIFICATE OF DEATH

60925

Reg. Dist. No. 284

1. PLACE OF DEATH:

County Talbot

City or town Tilghman
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lybrand Mister

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

8. (b) Name of husband or wife Earle Pritchett

7. Birth date of deceased (mo., day, yr.) Sept 15-1876 8. (c) If alive, give age 60 years

8. AGE: Years 69 Months 4 Days 11 If less than one day

9. Birthplace Tilghman (Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Waterman

12. Name Mr. Mister

13. Birthplace Dorchester Co Md

14. Maiden name Frances Bramble

15. Birthplace Tilghman, Dorchester Co. Md.

16. Informant A. P. Pritchett

Address 2925 Nelson Place S.E. Washington

17. Burial Date thereof Jan 28 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Tilghman

16. Funeral director Newnam & Harrison

Address St. Michaels. Ind.

19. 1/28 19 46 G. F. Jackson
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Talbot County Talbot

City or town Tilghman
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 28 19 46, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 19 46, to Jan 28 19 46

and that I last saw him alive on Jan 25 19 46

Immediate cause of death coronary occlusion DURATION 5 years

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. F. Jackson M. D. or other

Address Tilghman Md Date signed Jan 28 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NEW YORK STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME AND RESIDENCE OF DECEASED

DATE OF DEATH

HISTORICAL INFORMATION

RECEIVED
FEB 5 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 290

00926

1. PLACE OF DEATH:

County Talbot
 City or town Royal Oak
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 years
 Hospital, institution, or street address where death occurred
One Route from Royal Oak to Easton via Memorial Hospital Ambulance
 How long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Royal Oak
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

DANIEL THOMAS OREM

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced MarriedB. (b) Name of husband or wife Esthelle Cary Orem7. Birth date of deceased (mo., day, yr.) May 10, 1865 8. (c) If alive, give age _____ years8. AGE: Years 80 Months 8 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Church Creek, Md.
(Town, county, and state)10. Usual occupation Retired11. Industry or business U. S. Post Office Dept.12. Name Daniel Thomas Orem13. Birthplace Church Creek, Md.14. Maiden name Dorothy Ann Dreich15. Birthplace Church Creek, Md.16. Informant Mrs. Esthelle Cary OremAddress Royal Oak, Md.17. Burial (Burial, cremation, or removal) (Which?) Date thereof Jan 31, 1946
(month) (day) (year)Cemetery or crematory WoodlawnLocation Baltimore, Md.18. Funeral director R. C. ClarkAddress Easton, Md.19. 1/31 19 46 N. H. Meurer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28, 1946 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____.

Immediate cause of death Coronary occlusion DURATION Instant.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Louis P. Neely, M.D. Deb Med Soc
M. D. or otherAddress Easton, Md. Date signed 1-29-46

Def. 42 923-

926 missing

made 923 - 926

A.S. 2/28/47

RECEIVED

FEB 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48

CERTIFICATE OF DEATH

Reg. Dist. No. 00927 290

1. PLACE OF DEATH:

County... Salisbury
 City or town... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 das.
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 11 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Queen Anne Co.
 City or town Queenstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name War _____

3. (a) FULL NAME

Katherine B. Paea

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife sister Mrs. H. H. Bishop
 7. Birth date of deceased (mo., day, yr.) Sept. 22, 1875 6.(c) If alive, give age _____ years
 8. AGE: Years 70 Months 3 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Carmichael Md
 (Town, county, and state)

10. Usual occupation Real Estate

11. Industry or business Retired

12. Name Edward Edgumae Paea

13. Birthplace Wye Island Md

14. Maiden name Katherine B. Carmichael

15. Birthplace Wye Island Md

16. Informant Mrs. H. H. Bishop

Address Queenstown, Md

17. Burial Date thereof Jan 11-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul's Church, Md

Location John D. Williams

18. Funeral director Easton Md

Address _____

19. 1/9 19 46 H. A. Neer
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 19 46 at 6:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 28 19 45 to January 8 19 46

and that I last saw her alive on January 8 19 46

Immediate cause of death _____

Carcinoma of uterus DURATION 6 mo

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R S Co M. D. or other _____

Address Salisbury Md Date signed 1-9-46

RECEIVED

JAN 14 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00928

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Prince Georges
 City or town Prince Georges
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yrs.
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince Georges
 City or town Prince Georges
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth A. Pearson

3. (b) Social Security Number

✓

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

August 3, 1879

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

66419

hrs.

min.

9. Birthplace

Titusville Pa.
(Town, county, and state)

10. Usual occupation

Nurse

11. Industry or business

FATHER
MOTHER

12. Name

Frank Pearson

13. Birthplace

Ireland

14. Maiden name

Agatha Manning

15. Birthplace

Ireland

16. Informant

Mrs. John Wiley

Address

375 Newbark Place, Capitol Hill

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 26, 1946
(month) (day) (year)

Cemetery or crematory

St. Anthony's Cemetery

Location

Titusville Pa.

18. Funeral director

William Clark

Address

Easton Md.

19.

(Date rec'd by registrar)

19 46W.H. Nevin
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

January 22

at

11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 19, 1946, to January 22, 1946and that I last saw him alive on January 17, 1946

Immediate cause of death

Coronary Thrombosis

DURATION

Due to

Coronary Thrombosis

Due to

Other conditions

Mitral Stenosis

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

J. Edgar Baker M.D.
M. D. or other

Address

EastonDate signed 1-23-46

RECEIVED

JAN 29 1946

BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *2002*

CERTIFICATE OF DEATH

Reg. Dist. No.

00930-291

1. PLACE OF DEATH: County <u>Salbot</u> City or town <u>St Michaels</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Life</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md</u> County <u>Salbot</u> City or town <u>St Michaels</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war			
3.(a) FULL NAME <u>Wm Nicholas Seymour</u>				3.(b) Social Security Number <u>718-11-1624</u>			
4. Sex <u>male</u>		5. Color or race <u>white</u>		6.(a) Single, married, widowed, or divorced <u>widowed</u>			
6.(b) Name of husband or wife <u>Elizabeth Marshall</u>				6.(c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>May 10th 1870</u>				8. AGE: Years <u>75</u> Months <u>1</u> Days <u>1</u> If less than one day hrs. min.			
9. Birthplace <u>St. Michaels, Md</u> (Town, county, and state)				10. Usual occupation <u>Waterman</u>			
11. Industry or business				12. Name <u>William F. Seymour</u>			
13. Birthplace <u>St. Michaels, Md</u>				14. Maiden name <u>Clersia Marshall</u>			
15. Birthplace <u>St. Michaels, Md</u>				16. Informant <u>Carrol Seymour</u>			
Address <u>St. Michaels, Md</u>				17. Burial <u>Jan 30, 1946</u> (Burial, cremation, or removal, Which?) (month) (day) (year)			
Cemetery or crematory <u>Christ Cemetery</u>				Location <u>St. Michaels, Md</u>			
18. Funeral director <u>Newnam & Harrison</u>				Address <u>St. Michaels, Md</u>			
19. <u>Jan 29th 1946</u> (Date rec'd by registrar)				20. <u>John H. Hovavale</u> Registrar			
MEDICAL CERTIFICATION							
2D. DATE OF DEATH <u>Jan. 29th 1946</u> at <u>Home</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>1946</u> and that I last saw him <u>alive on</u> <u>Jan 29th 1946</u> <u>called me</u> <u>on not know</u>							
IMMEDIATE CAUSE OF DEATH							
DURATION							
Due to							
Due to							
Other conditions							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Date of op.							
Autopsy results							
PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following:							
Accident, suicide, or homicide							
Where did injury occur?							
(City or town) (County) (State)							
Injured at home, farm, industry, public place (where?)							
Means of injury Injured at work?							
23. SIGNATURE <u>S. D. Humphreys</u> M. D. or other							
Address <u>St. Michaels, Md</u> Date signed <u>Jan 29th 1946</u>							

REPUBLIC OF THE UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

RECEIVED
FEB 5 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

 00931
 Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot
 City or town Newcomb
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Talbot
 City or town Newcomb
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Charles M. Smith

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower
 6. (b) Name of husband or wife unknown
 7. Birth date of deceased (mo., day, yr.) March 14, 1876 8. (c) If alive, give age _____ years
 8. AGE: Years 69 Months 9 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Somerset Co. Ind
 (Town, county, and state)
 10. Usual occupation Carpenter
 11. Industry or business _____

12. Name unknown
 13. Birthplace unknown
 14. Maiden name unknown
 15. Birthplace unknown

16. Informant John Smith
 Address Newcomb Ind

17. Burial (Burial, cremation, or removal. Which?) Burial Date hereof Jan 9, 1946
 (month) (day) (year)
 Cemetery or crematory Cemetery
 Location near St. Michaels.

18. Funeral director Newnam & Harrison
 Address St. Michaels, Ind

19. Jan 8 19 46 John H. Hyslop
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 January 19 46 at 4 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 May 19 45 to 7 January 19 46
 and that I last saw him alive on 31 December 19 45

Immediate cause of death Coronary thrombosis
 DURATION 7 mo 7 d

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE W. B. Perkins M.D. M. D. or other 11/86
 Address Royal Oak Ind. Date signed _____

STATE OF MONTANA DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
FEB 5 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 122

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: Saskatoon
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 27 N. Hanson St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME Russell Sautsky

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 13, 1981
 B. (c) If alive, give age..... years

8. AGE: Years 64 Months 4 Days 18 If less than one day
hrs.min.

9. Birthplace Boston, Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Charles J. Sautsky13. Birthplace Md.14. Maiden name Mary O. Sautsky15. Birthplace Pa.16. Informant Mrs. Mary O. SautskyAddress Boston, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan 5, 1946
 (month) (day) (year)

Cemetery or crematory Spring HillLocation Boston, Md.18. Funeral director W. H. NeerAddress Boston, Md.

19. 1/2 46 W. H. Neer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1946, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 31, 1945 to Jan. 1, 1946and that I last saw him alive on Jan. 1, 1946

Immediate cause of death.....

Generalized abdominalperitonitisDue to Ruptured diverticulumof sigmoid

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE J. J. Baker M.D.Address Boston Date signed 1-3-46

M. D. or other

RECEIVED

JAN 10 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

CERTIFICATE OF DEATH

00932

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Ellipt CountyCity or town Easton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memoir Hospital

How long in hospital or institution?

4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Preston
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Mr. William Tidwell

3. (b) Social Security Number

154-05-1263

4. Sex

M

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widower

8. (b) Name of husband or wife

Steven M. Adams

7. Birth date of

deceased (mo., day, yr.)

1883

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

62

.....hrs.min.

9. Birthplace

Unknown
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

Unknown

13. Birthplace

"

MOTHER

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

Address

R. Ellis Clark
Easton Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

1/14/46
(month) (day) (year)

Cemetery or crematory

White Marsh Mem. Park

Location

Quiller Pay
R. Ellis Clark
MD.

18. Funeral director

Address

Easton, Md.

19.

(Date rec'd by registrar)

1/1546N. H. Norris

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-11 1946, at 2 A. 56

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-6- 1946, to 1-11- 1946
and that I last saw him alive on 1-11- 1946

Immediate cause of death

Heart failure, due to internalDue to Due to Cirrhosis of LiverDue to Not due to cancer, liver

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE

Address Easton Md Date signed 1-14-46

RECEIVED

JAN 23 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00934

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County TalbotCity or town St. Michaels, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Lucie S. Wharton

3. (b) Social Security Number

none4. Sex Female5. Color or race white6. (c) Single, married, widowed, or divorced widow6. (b) Name of husband or wife John E. Wharton7. Birth date of deceased (mo., day, yr.) May 20 1864

8. (c) If alive, give age years

8. AGE: Years 81 Months 7 Days 22 If less than one day
..... hrs. min.9. Birthplace St. Michaels.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Josiah Fairbank13. Birthplace St. Michaels, Talbot Co. Md.14. Maiden name Harriet Hambleton15. Birthplace St. Michaels, Talbot Co. Md.16. Informant John E. WhartonAddress St. Michaels, Md.17. Burial Burial Date thereof Jan 15, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Clinton CemeteryLocation St. Michaels, Md.18. Funeral director Newnam & HarrisonAddress St. Michaels, Md.19. Jan 14 1946 John H. Hester
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 11, 1946 19....., at..... M

21. I CERTIFY the death occurred on the date above stated; that I attended deceased from

Jan. 9, 1946 19....., to Jan 11, 1946and that I last saw him/her alive on Jan 10, 1946 19.....Immediate cause of death Mitral Disease DURATIONDue to Chr. Rheumatoid ArthritisDue to 2 yrs

Due to

Other conditions Aortic Aneurysm

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date ofWhere did injury occur? ✓ (City or town) (County) (State)Injured at home, farm, industry, public place (where?) ✓Means of injury ✓ Injured at work? ✓23. SIGNATURE St. Michaels, Maryland M. B. or otherAddress St. Michaels, Maryland Date signed 1.14.46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAINTAIN STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

DATE OF DEATH

DEPARTMENT OF HEALTH

RECEIVED

FEB 5 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

00933

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... Talbot County
 City or town... Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 1/2 hrs.
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 6 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Talbot
 City or town... Easton Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Maria Wheeler

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Elliot Wheeler
 7. Birth date of deceased (mo., day, yr.) June 21, 1894 6. (c) If alive, give age years
 8. AGE: Years 54 Months 6 Days 19 If less than one day hrs. min.
 9. Birthplace Royal Oak Ind.
 (Town, county, and state)
 10. Usual occupation H.W.

11. Industry or business

FATHER 12. Name Wm. O'Sullivan Triphal
 13. Birthplace Baltimore Ind.
 MOTHER 14. Maiden name Maria Trinelee
 15. Birthplace Baltimore Ind.
 16. Informant Thomas Martin
 Address Easton Ind.

17. Burial Date thereof Jan 10 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oxford Ind.
 Location Oxford Ind.
 18. Funeral director John A. Williams
 Address Easton, Md.
 19. 19 46 M.D. Neirin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-9 19 46, at 2 A M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 9 46 to Jan 9 9 46
 and that I last saw him alive on Jan 9 9 46

Immediate cause of death G.S.W. head
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide suicide Date of 1-9-46
 Where did injury occur? hr. Easton Talbot Ind
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) home
 Means of injury G.S.W. Injured at work? no
 23. SIGNATURE Louis S. Sweet, M.D. Dep. Health
 Address Easton Ind. Date signed 1-10-46

RECEIVED

JAN 14 1946

BUREAU V.S.